# BRITISH CARDIAC SOCIETY NEWSLETTER

During a recent meeting at the Medical Devices Directorate at the Department of Health, we became aware of a problem that will be of interest to cardiologists who are active in the field of resuscitation. It concerns battery packs for portable defibrillators. Some hospitals and ambulance stations use battery packs that are not supplied by the defibrillator manufacturer because this is a cheaper option. It is not always a wise one, however. Some batteries from alternative sources have poor performance characteristics that have resulted in investigations of apparent defibrillator defects and the issue of Safety Action Bulletins. The Department of Health has told us that tests of unauthorised battery packs showed significant overheating during successive 360 J charges leading to a loss in capacity, a longer time than is specified for charging, and a reduced number of shocks per full battery charge. Readers should know that manufacturers classify the battery pack of a defibrillator as a critical component in their agreements under the agreed quality document (Good Manufacturing Practice for Medical Equipment). The quality and form of the design of defibrillator batteries, the inspections, quality testing, and traceability all make legitimate additions to the cost of this high specification equipment that may not be necessary or appropriate for battery packs intended for less demanding or critical use. We should add that some alternative battery suppliers are now in the process in installing quality systems that would satisfy the department and may in time be recognised by the NHS in its purchasing policy. But considerable responsibility is placed with the user who elects to use substitute batteries and we suggest that suppliers be requested to demonstrate and perhaps give a written undertaking that their design allows equivalent performance to that in batteries supplied by the manufacturer of the defibrillator.

The recent distribution of the current list of British Cardiac Society committees and their membership has drawn the comment that the same names do seem to recur with undue frequency. To this we plead guilty. The society has officers who number four or five (the President elect is a post sometimes filled and sometimes not). We do believe it is essential to have at least two officers on every committee to ensure that we act cohesively. Officers do not seek to dominate committees—though some have additional influence because they are chairmen. Perhaps it is also fair to mention that before we had our new committee structure, all decisions were necessarily made by the officers, by council, and at general meetings by the membership. If we now have an additional way for members who are not on Council to have influence in areas of their interest or expertise, this should not be seen as a move away from democracy. But two issues need to be addressed. The first is how to identify members who seek this sort of involvement: we often find it difficult to persuade colleagues to take on new responsibilities that can be time consuming and even difficult to arrange in these days of stricter contracts. Please tell us if you have an interest in any of the committees and would be willing to serve. The second related issue is how to make decisions on representation on the committees, having regard to the need for balance: we always consider the balance between London and out-of-London, between North and South (and, to the West, Ireland), between younger and older, between academic and NHS, between the centres and the district general hospitals, and between adult and paediatric cardiology. Clearly we cannot achieve a satisfactory mix on committees with limited membership, but the balance could easily become less satisfactory. For this reason we have taken the view that council are elected, and that the composition of committees should be left to them—but with influence from the wider membership always welcome. Is this reasonable?

Readers will know we are anxious to promote opportunities for part time training in cardiology. The BMA have arranged a seminar for any junior doctors interested in part time training. It will be held in the Roben Suite at Guy's Hospital at 6.30 pm (for 7.30 pm) on 11 November. Further information can be obtained from David Barr on 081-660 5558.

Attilio Maseri has now left the Royal Postgraduate Medical School to take up a new appointment in Italy. His influence has been great, and we cannot let his departure pass without comment. John Goodwin has written the appreciation that follows.

"Attilio Maseri became the British Heart Foundation Sir John McMichael Professor of Cardiovascular Medicine at the Royal Postgraduate Medical School in 1979. His previous career was distinguished. Training in Padua, in Pisa, and in the United States (Columbia and John's Hopkins) had equipped him for a career in research in nuclear cardiology and coronary artery disease. By 1969, he was head of the coronary research group in the laboratory of clinical physiology of the National Research Council in Pisa, and the following year became the Professor of Cardiopulmonary Pathophysiology. His chief interests were in radionuclide studies of myocardial blood flow, regional myocardial perfusion and metabolism, and the pathogenetic mechanisms of acute myocardial infarction. But he was best known for his original studies in coronary artery spasm. Later, while at the Royal Postgraduate Medical School, he extended his range to include mechanisms of coronary occlusion in acute myocardial infarction with colleagues in cardiology, and to the role of neuropeptide and other transmitters in the control of the circulation, in collaboration with Stephen Bloom and Julia Pollak.

Attilio brought to Hammersmith Hospital a cool critical look at basic mechanisms that was most refreshing. The Royal Postgraduate Medical School has always eagerly welcomed exciting new talent from outside Britain, and Attilio has been a prime example.

As the second Professor of Cardiology in the United Kingdom and the first at the Royal Postgraduate Medical School, I welcomed the new professorial blood with enthusiasm. It was a pleasure to work with him in the realm of teaching. Together we set up the first diploma course in cardiology, loyally aided by many colleagues. Attilio's specialist courses in cardiology, often held in association with other institutions such as the European Society of Cardiology and the American College of Cardiology, were highly successful and attracted many well known international speakers in addition to large enthusiastic audiences.

While at Hammersmith, he gave a number of notable named lectures in the United Kingdom, the United States, Europe, and Japan, and became a member of many important scientific councils such as the National Italian Research Council and the Council on Thrombosis of the International Society and Federation of Cardiology. In addition to many other professional awards and titles, Attilio will be well remembered at Hammersmith Hospital for his and Francesca's generous hospitality in their home.

I have appreciated Attilio as a charming, helpful, and enthusiastic colleague. He takes the best wishes of us all with him to his important new appointments as Professor of Cardiology in the Catholic University of Rome and Director of the Institute of Cardiology, Polyclinico Agostino Gamelli. We hope he will keep in regular touch and visit often."

John Goodwin's appreciation is warmly endorsed by all of us.

This issue of the *British Heart Journal* contains the Sixth Biennial Survey on Staffing and Facilities in Cardiology in the UK (1990). Readers will no doubt study all the data carefully. It may be worth drawing your attention to the fact that there are still 44 districts in England and Wales with no cardiologist or only an occasional visiting cardiologist. We perceive an overall requirement for over 150 more consultant cardiologists to meet existing needs, but even the present rate of expansion is going to lead to a dearth of senior registrars in the last few years of this decade. Although these data are available and irrefutable, the formula for adjusting the number of senior registrar appointments (Joint Planning Advisory Committee) does not permit any expansion to meet this need. Unless the ground rules are changed, we are heading for a crisis.

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